

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Ahc Millenium		STREET ADDRESS, CITY, STATE, ZIP CODE 5275 Millennium Drive Huntsville, AL 35806	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews and medical record review the facility failed to ensure Resident Identifier (RI) #335's representative was notified of an incident and that he/she transferred to the hospital on 06/24/2024.</p> <p>This deficient practice affected RI #335 one of three residents reviewed for transfer and discharge.</p> <p>Finding Include:</p> <p>RI #335 was admitted to the facility on [DATE] with diagnoses of Dementia with Agitation and Major Depressive Disorder.</p> <p>A review of RI #335's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/08/2023, indicated RI #335's BIMS (Brief Interview for Mental Status) as five of 15, indicating RI #335 was cognitively impaired.</p> <p>A review of RI #335's Clinical Notes Report dated 06/24/2024, revealed RI #335 was transferred to the hospital on 06/24/2023 after an increase in aggressive behaviors. There was no documentation in the Clinical Progress Notes that the representative sponsor was notified of the incident and the resident transfer to the hospital on 06/24/2023.</p> <p>On 06/14/2024 at 2:00 PM an interview was conducted with RI #335's representative/sponsor. She was asked when was she made aware of the incident that happened on 06/23/2023 regarding and RI #335 that resulted in RI #335 being transferred to the hospital. The sponsor stated she was not made aware of the incident by the facility, but by the hospital social worker and then she called the facility. She further stated RI #335 had been in the hospital for a few days before she was aware of the incident and being in the hospital.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews, medical record reviews, the facility's policy titled, Abuse Prohibition Plan, the Facility Reported Incident (FRI) received by the Alabama State Survey Agency, and the facility's investigative file, the facility failed to protect Resident Identifier (RI) #334's right to be free from physical abuse by another resident, RI #335.</p> <p>During lunch on 06/23/2023 RI #335 was physical and verbally abusive to staff and expressed suicidal and homicidal ideations. RI #335 was sent to the local hospital's emergency room around 1:00 PM. Upon return from the hospital around 3:00 AM, RI #335 was not supervised and went from his/her room, through the bathroom that connected to RI #334's room.</p> <p>On 06/24/2023 at approximately 4:30 AM, RI #335 was witnessed by a CNA (Certified Nursing Assistant) in RI #334's room, standing over RI #334's bed with a pillow over RI #334's face gripping both sides and pushing with force.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect and Exploitation at F 600- Free from Abuse and Neglect.</p> <p>On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation at F 600- Free from Abuse and Neglect.</p> <p>The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>This deficiency was cited as a result of a Facility Reportable Investigation/Complaint/Report Number AL00044582.</p> <p>This deficient practice affected one of seven residents reviewed for abuse and neglect prevention.</p> <p>Findings Include:</p> <p>Cross Reference F 740</p> <p>A review of the facility's policy titled, Abuse Prohibition Plan, with an effective date of 04/01/2018, revealed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>. Purpose: The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse, corporal punishment . is prohibited. The resident shall not be subjected to mistreatment, neglect . The Abuse Policy applies to anyone involved with the residents of this facility, including, but not limited to all facility staff, other residents .</p> <p>Definitions: .</p> <p>Abuse means the willful infliction or injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, . of good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish . It includes . physical abuse, and mental abuse .</p> <p>Willful means the individual deliberately, not that the individual must have intended to, inflict injury harm.</p> <p>Physical Abuse includes but not limited to hitting, slapping, pinching, and kicking.</p> <p>Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p> <p>Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative visitor, another healthcare provider, . if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse .</p> <p>B. TRAINING</p> <p>All employees shall receive training during initial orientation, annually and with ongoing sessions . Training shall include, but is not limited to the following:</p> <p>. 2. Resident Rights</p> <p>3. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property and exploitation .</p> <p>6. How to identify residents who are at risk for abuse, neglect, .</p> <p>8. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include, but are not limited to:</p> <p>a. Aggressive and/or catastrophic reactions of residents .</p> <p>b. Wandering or elopement type behaviors .</p> <p>c. Resistance to care;</p> <p>d. Outburst or yelling out .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>C. PREVENTION</p> <p>It is the policy of this facility . To prevent potential abuse, the facility leadership shall assess the needs of residents in the facility and the environment to identify concerns.</p> <p>F. PROTECTION</p> <p>It is the policy of this facility that Residents shall be protected from the alleged offender (s) .</p> <p>RI #335 was admitted to the facility on [DATE] with diagnoses that included Dementia with Agitation and Major Depressive Disorder.</p> <p>A review of RI #335's Admission MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of 05/08/2023, indicated RI #335's Brief Interview for Mental Status (BIMS) as five of 15, which indicated that RI #335 was cognitively impaired.</p> <p>RI #334 was admitted to the facility on [DATE] with diagnoses that included Dementia and Weakness.</p> <p>RI #334 Admissions MDS with ARD date of 04/11/2023 indicated RI #334 had a BIMS of seven of 15 which indicated RI #334 was cognitively impaired.</p> <p>A review of RI #335's care plan with a Problem Onset Date of 09/28/2022 documented: Altercation with another resident . (RI #335) has a history of verbal aggressive behavior towards family, . hx (history) of wandering behavior . hx of . Resident has threatened to kill his/her daughter and his/her family . Confusion, alteration in thought process related to (RI #335) has dementia .</p> <p>A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #30 and dated 06/23/2023 at 12:00 PM, revealed the following:</p> <p>. Called into the dining room by restorative cna and activities director. Was informed that this resident was going off and had thrown juice all over the staff and floor, saw staff wet clothes, and this resident standing near door. Walked up to resident and resident starting telling activities director that this writer was in on it and then resident grabbed this nurse by the wrist and pulled this nurse toward him/her. This nurse pulled away from resident's grip and then resident began advancing toward this nurse . Was visibly angry and upset, would not leave dining room. Administrator walked in and was able to get him/her to leave . Before leaving, resident said, everyone in this room is going to get killed .</p> <p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:16 PM, revealed the following: resident stated he/she knows something is wrong in his/her head and feels that he/she would rather be gone then he/she hurt someone</p> <p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:59 PM, revealed the following: Stated that if he/she had a gun in front of him/her he/she would shoot himself/herself. Continue to make comments about get rid of me and I'm gonna do it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of RI #335's Clinical Notes Report entered by the Social Services Designee (SSD) dated 06/23/2023 at 1:32 PM, revealed the following: I sent information to (name of Psychiatric Facility) for (RI #335) to go over there due to behavior. I was trying my best to get him/her . next door instead of going to ER . I called (name of Mental Health Center) to see if they could speed up the process of getting him/her over there. No one responded, so they sent him/her to the ER (emergency room) .</p> <p>A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #18 dated 06/24/2023, revealed the following:</p> <p>Resident brought by .to facility at 3 AM . no new orders given . he/she did not know why he/she was sent to hospital.</p> <p>A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: .</p> <p>Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room. called the administrator and she said send him/her back to the (name of hospital) .</p> <p>On 06/24/2023 at 8:59 AM the facility submitted a report to The Alabama Department of Public Health Online Incident Reporting System. The report indicated at 4:30 AM RI #334 .was found in bed with another resident over him/her with a pillow in his/her hand. Other resident had pillow over resident face . Residents were immediately separated. Aggressor resident was placed on one on one supervision until ambulance arrived and he/she was sent to the hospital. Other resident was assessed head toe for any signs of injury. None noted. Assessment attempted to see if incident caused any distress to resident. Hard to determine due to resident mental condition . The report indicated the incident was report to the Assistant Director of Nursing (ADON), Director of Nursing (DON) and Administrator (ADM) who then reported to medical director, corporate office, state, adult protective services, and local police.</p> <p>The facility's undated incident summary documented the resident on resident Physical was substantiated. The reports summary documented:</p> <p>.Summary:</p> <p>On 06/24/2023 at approximately 4:30-5:00 a.m. the CNA heard the door slam and went to check on what (RI #335) was doing. He/She wasn't in his/her room and found him/her in (RI #334's) room with a pillow over (RI #334's) face with him/her moving his/her arms and legs. CNA immediately pulled (RI #335) away and moved the pillow, she removed (RI #335) from the room, he/she was placed on one-to-one with the nurse . medical director was notified and (RI #335) was sent to (name of hospital) . The immediate intervention was to separate see if incident cause any distress. Psychosocial assessment difficult due to his/her mental condition .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>After concluding the investigation which included obtaining statement from all involved staff, interviewing residents with a BIM's of 13 and over to ensure resident that was engaging in behaviors not came into their room on the date of concern . We notified the police of incident and (RI #335) was sent to (name of hospital) by (name of ambulance).</p> <p>Unsuccessful attempts were made to interview CNA #27, the witness of the incident, on the phone several times during the survey.</p> <p>An undated written statement from CNA #27 documented: At approx (approximately) 4:30 AM I heard a door slam down 101 hall I went down the hall and checked in room and resident in room, so I walked through adjoining bathroom and noticed resident (RI #335) standing over . (RI #334) holding a pillow over his/her face/head. Resident was gripping pillow on both sides and pushing with force. (RI #335) was immediately removed from room . and was placed 1 to 1 with the nurse. The other nurse came . The resident (RI #334) . was ok .</p> <p>An undated witness statement from RI #188, a resident who was discharged at the time of the survey documented: (typed) Did any resident wake you up last night? . (handwritten) Yes . Resident stated the aggressor came in his/her room and was yelling and screaming leave him/her alone and don't touch him/her resident said the aggressor was talking to himself/herself. Resident said he/she was afraid because the aggressor was running in and out of his/her room and bathroom .</p> <p>An undated witness statement from another resident, RI #33 documented: (typed) Did any resident come in your room last night? (handwritten) Yes, a female/male resident walked in to my room with a vase in his/her hand, walked in bathroom, and then CNA came and got him/her and walked him/her out. He/She was yelling, leave me alone .</p> <p>On 06/13/2024 at 12:10 PM, a telephone interview was conducted with the Former Assistant Director of Nursing (FADON). The FADON was asked about the incident that occurred on 06/24/2023 with RI #334 and RI #335. She stated, she was told that a CNA was walking past the room and observed RI #335 with a pillow over RI #334's head, the CNA immediately intervened by separating RI #335 from RI #334. FADON said that she considered this incident to be resident to resident physical abuse, she further said that RI #335 had been exhibiting aggressive, impulsive, and combative behaviors prior to this incident.</p> <p>On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table.</p> <p>On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital because he/she was not gone over 24 hours. RN #18 said between 3:00 AM and 4:30 AM, the CNA was walking the halls and saw RI #335 with the pillow over RI #334's face. She further stated, the CNA intervened and stopped RI #335, and RI #335 ran back to his/her room and the CNA followed. RN #18 said RI #335 was placed on one-on-one supervision until discharged to the hospital.</p> <p>On 06/14/2024 at 12:05 PM an interview was conducted with Regional Nurse Manager (RNM). The RNM said incident that occurred on 06/24/2023 regarding RI #335 was substantiated as physical abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*****</p> <p>On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which documented:</p> <p>Safety:</p> <ol style="list-style-type: none"> 1. Resident's #334 and #335 were separated by the CNA on 6/24/23. <p>Assessment:</p> <ol style="list-style-type: none"> 2. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted. 3. On 06/26/2023 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings. 4. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMS and ultimately discharged . 5. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 06/24/2023 with no negative findings. 6. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 06/24/2023 with no negative findings. 7. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 06/24/2023 by the Administrator. 8. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 06/11/2024 and 06/18/2024 with no negative findings. 9. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing, Staffing Coordinator, and Charge Nurse on 06/11/2024 with no negative findings. <p>Notification:</p> <ol style="list-style-type: none"> 1. On 06/24/2023 Charge Nurse made notifications to the practitioners and responsible parties for resident #334 and #335. <p>Audits:</p> <ol style="list-style-type: none"> 2. Clinical Record Review from 03/01/2024 to 06/16/2024 was initiated on 06/16/2024 and completed on 06/17/2024 by the Director of Clinical Education and Regional Nurse Managers to include clinical notes, event notes, and daily skilled notes to identify any potential residents for instances of physical abuse, with no unknown new findings. <p>In-services:</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. On 06/16/2024 Inservice was provided by the Assistant [NAME] President of Operations and the Regional Nurse Manager to the Administrator, DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress and combative behaviors and suicidal/homicidal ideation. Education was also provided regarding staff unavailable to receive education will not be permitted to work until required education is completed.</p> <p>The Staffing Coordinator was designated as responsible for ensuring staff are educated on abuse prohibition plan, behavioral health services policy, and list of interventions for behaviors</p> <p>2. On 06/16/2024 Inservice was provided by the DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behaviors and suicidal/homicidal ideation to all staff. Staff unavailable to receive education will not be permitted to work until the required education is completed. 73 out of 77 employees have been educated.</p> <p>3. On 06/16/2024 competency and validation questions were answered by staff currently working to ensure competency verbalized from education received.</p> <p>4. On 06/17/2024 the Regional Nurse Manager placed signage in break rooms, nurses stations, and behavior communication binders that list interventions for behaviors including abuse, aggressive, distress and combative behaviors and suicidal/homicidal ideation.</p> <p>QAPI:</p> <p>1. Adhoc QAPI was conducted on 06/24/2023 to include Administrator, Director of Nursing, Senior [NAME] President of Operations, Assistant [NAME] President of Operations, Regional Nurse Manager, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager to discuss resident to resident altercation event, education, root cause, and interventions.</p> <p>2. The Medical Director was notified of the immediate jeopardy citations on 06/16/2024 by the Assistant [NAME] President of Operations.</p> <p>3. A Root cause analysis was conducted on 06/16/2024 by the Administrator, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Directors of Nursing, Assistant [NAME] President of Quality, Director of Clinical Education. Root cause was identified as ineffective training and education related to behavioral health services.</p> <p>4. QAPI meeting was conducted on 06/16/2024 to include Administrator, Director of Nursing, Staffing Coordinator, Dietary Manager, Activity Coordinator, Treatment Nurse, Receptionist, MDS Coordinator, Social Service Director, Business Office Manager, Maintenance Director, Regional Nurse Manage, Assistant [NAME] President of Operations, Regional Nurse Manager, Medical Director, Assistant [NAME] President of Clinical Operations, Senior [NAME] President, and Director of Clinical Education regarding Immediate Jeopardy citations, Abuse and Behavior Health Services policy review, education, interventions for immediate removal plan, Medical Director notification, facility assessment updated/reviewed and root cause analysis determined.</p> <p>a. Abuse Prohibition Plan reviewed with no recommendation for changes 06/16/2024</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b. On 06/16/2024 the Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideation's (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services.</p> <p>c. On 06/16/2024 Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, combative, and Suicidal and Homicidal Ideations.</p> <p>d. On 06/16/2024 the facility assessment plan was revised to include suicidal ideations.</p> <p>5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9 PM to discuss the corrective action plans to address the immediate concerns for F 600 for Resident's #334 and #335 and all current residents have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations.</p> <p>Facility implemented all corrective Actions on 6/18/2024.</p> <p>*****</p> <p>After a review of documentation supporting the above corrective actions, including the facility's investigative file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implement corrective actions including ongoing monitoring on 06/18/2024.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>33739</p> <p>Based on record review, interviews, the Facility Reported Incident (FRI) received by the Alabama State Survey Agency, and the facility policy titled Abuse Prohibition Plan, the facility failed to protect Resident Identifier (RI) #40's right to be free from misappropriation of property when Registered Nurse (RN) #6 placed RI #40's temazepam in her pocket and left the facility.</p> <p>This affected RI #40 one of seven residents sampled for abuse prevention.</p> <p>This was cited due to the investigation of facility reported incident/complaint/report number AL00047874.</p> <p>Findings Include:</p> <p>Review of a facility policy titled Abuse Prohibition Plan, with an effective date of 11/02/2023 documented .</p> <p>Purpose:</p> <p>. The resident shall not be subjected to . misappropriation of property .</p> <p>Definitions: .</p> <p>Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.</p> <p>RI #40 was admitted to the facility 12/18/2022.</p> <p>On 05/16/2024 at 3:26 PM the facility reported an incident by way of The Alabama Department of Public Health Online Reporting Incident System. The report indicated that the facility was notified on 05/16/2024 by a Drug Enforcement Agency (DEA) Officer that RN #6 was found with a white substance in her possession during a K-9 search at her other job. The DEA Officer reported that RN #6 told the officer it was a temazepam from RI #40 that was refused and she placed in her pocket to return or destroy later. The report indicated that RN #6 said she forgot it was in her pocket until discovered by the DEA Officer several months later.</p> <p>On 06/12/2024 at 10:46 AM during an interview with DEA Officer, he said routinely the correctional facility performed K-9 search and on 05/16/2024 a search of employees was conducted. The search found a white substance which was in RN #6's wallet in her purse. It was sent to the lab, tested , and returned as temazepam. He said in questioning RN #6 she said it was from the facility. He said RN #6 gave the name of RI #40, said the resident had refused the medication and she put it in her pocket instead of getting the other nurse to destroy with her. He said she was arrested for possession of a controlled substance and theft.</p> <p>Interview with resident RI #40 on 06/12/2024 at 11:27 AM said he/she did not recall refusing sleeping pill but might have. When RI #40 was told it might have been in January he/she said too long ago.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/12/2024 at 11:00 AM during an interview with the facility Regional Nurse Manager (RNM) he said he worked on this investigation. He said the DEA officer called and told found white substance on RN #6 during a K-9 search at the correction facility while working. The RNM said RN #6 said RI #40 refused the medication and she put it in her pocket. He said they were notified of the incident on 05/16/2024 and the best they could gather it occurred 01/07/2024. He said it was abuse by misappropriation when RN #6 placed the medication in her pocket.</p> <p>On 06/12/2024 at 3:07 PM during an interview with RN #6, she said she went to give RI #40 the temazepam the last time she worked at the facility January 2024. RN #6 said RI #40 said he/she did not want it. RN #6 said she put it in a plastic bag and in her pocket. She said she did not recall the exact date. She said she forgot to get the other nurse to come destroy it with her, and when she got home, she realized it was still in her pocket, so she put it in her wallet in her purse and forgot about it. She said she worked at the correctional facility and a K-9 search was done and it was found in her car. She said she was arrested and charged with possession and theft. She said she should never have placed the medication in her pocket.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>33738</p> <p>Based on interviews, medical record review, review of the facility reported incident and a review a of the facility policy titled, Abuse Prohibition, the facility failed to report an allegation of abuse within the time frame of two hours to the state Agency on 06/24/2023.</p> <p>On 06/24/2023 at 4:30 AM, the facility staff reported an allegation of physical abuse by</p> <p>RI #335. The facility reported the allegation of physical abuse at 8:59 AM on 06/24/2023 to ADPH (Alabama Department of Public Health) State Agency.</p> <p>This deficient practice affected one out of three sampled residents reviewed for abuse concerns.</p> <p>Finding Include:</p> <p>A review of the facility's policy titled, Abuse Prohibition Plan, with an effective date of 04/01/2018, revealed: . EXTERNAL REPORTING . All alleged violations are reported immediately, but not later than 2 hours after the allegations is made .</p> <p>On 06/24/2023 at 8:59 AM the facility submitted a report to The Alabama Department of Public Health Online Incident Reporting System. The report indicated staff became aware of an incident of physical abuse at on 06/24/2023 at 4:30 AM.</p> <p>An interview was conducted on 06/26/2026 at 9:39 AM with the Administrator (ADM).</p> <p>The ADM stated he was the Abuse Coordinator for the facility, and that all allegations of abuse should reported to our office (ADPH). When asked what was the time frame for reporting alleged physical, he said within two hours of discovery.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47408</p> <p>Based on interviews, record reviews and a facility policy titled Baseline Careplan, the facility failed to ensure Resident Identifier (RI) #72 received a copy of his/her Baseline Care plan Summary within 48 hours of admission. The facility further failed to ensure RI #72's Baseline Care Plan was developed within 48 hours of admission.</p> <p>This deficient practice affected one out three sampled residents whose baseline care plans were reviewed.</p> <p>Findings Include:</p> <p>RI #72 was admitted to the facility on [DATE] with admitting Diagnoses of Pleural Effusion, Pneumonia, Chronic Respiratory Failure with Hypoxia.</p> <p>A review of a facility policy titled, Baseline Careplan, dated 11/2016, Revised 10/25/2023: .Purpose:</p> <p>The facility shall develop and implement a baseline care plan for each resident that meet professional standards of quality care.</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. "The baseline careplan shall <ol style="list-style-type: none"> a. Be developed within upon a resident's admission . 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment .and discuss with the resident and resident representative . b. Interventions shall be initiated that address the residents current needs .c. Once established, goals and interventions shall be documented . 3. A supervising nurse shall verify that a baseline care plan has been developed . <p>On 06/13/2024 at 09:47 AM an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC reviewed the medical records and stated that she did not see a baseline care plan for RI #72. The MDSC was asked should RI #72 have had care plans within 48 hours and she replied, yes. The MDSC was asked who was responsible for initiating baseline care plans and the MDSC stated the Director of Nursing (DON) was responsible for initiating baseline care plans and MDSC initiated the complete Care Plans.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/2024 at 01:03 PM an interview was conducted with the DON. The DON was unable to locate RI #72's baseline care plan. The DON said admitting nurse was responsible for initiating a baseline care plan. The DON was asked why should a resident have baseline care plans and she stated to work in conjunction with the plan of care and for the health and well-being of the patient. The DON was asked should RI #72 have had baseline care plans and she replied yes.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews, record review and a review of a facility's policy titled, Oxygen Concentrator and Oxygen Storage, the facility failed to ensure:</p> <p>Resident Identifier (RI) #5 had a physician order for his/her oxygen and his/her oxygen tubing was labeled/dated.</p> <p>The facility further failed to ensure RI #52's nebulizer mask was stored in a plastic bag when not in use.</p> <p>This deficient practice affect RI #5 and RI #52, two of three residents sampled for respiratory care.</p> <p>Findings Include:</p> <p>A review of a facility's policy titled, Oxygen Concentrator . with an effective date of 12/01/2023 documented: .</p> <p>Purpose: To administer oxygen for the treatment of certain diseases or conditions .</p> <p>Policy: . Oxygen should be administered only under orders of the attending physician .</p> <p>Procedure: .</p> <p>1. Care of the Resident .</p> <p>a. Obtain physician's orders for the rate of flow and route of administration of oxygen (mask, nasal cannula etc.). Cannulas and masks should be change weekly .</p> <p>A review of RI #5's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 04/29/2024 Section O did not indicate oxygen therapy.</p> <p>A review of RI #5's Care Plan Report Effective 08/01/2023 indicated RI #5 required supplemental oxygen at times . change tubing one (1) times weekly starting 08/01/2023 . check/record oxygen saturation three times daily and check/fill humidifier one time daily .</p> <p>On 06/11/2024 at 4:00 PM, the surveyor observed RI #5's oxygen infusing via nasal cannula at three liters per minute. There was no date on the oxygen tubing.</p> <p>On 06/12/2024 at 5:54 PM, the surveyor observed RI #5's oxygen infusing via nasal cannula at 3 liters per minute. The tubing remained undated.</p> <p>On 06/13/2024 at 12:17 PM, the surveyor observed RI #5's oxygen was infusing via nasal cannula at 3 liters per minute. The tubing remained undated.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/2024 at 12:17 PM, Licensed Practical Nurse (LPN) #22 escorted the surveyor to RI #5's room. The surveyor asked LPN #22 did he see a date on RI #5's oxygen tubing. LPN #22 said no. LPN #22 said there should be a date on the tubing and a dated bag to store it in. When asked the rational for labeling the tubing and bag, LPN #22 said to let other staff know how long the tubing had been on the resident and when it was to be changed.</p> <p>On 06/13/2024 at 6:30 PM, the surveyor conducted an interview with Registered Nurse (RN) #23, a nurse supervisor. When asked if RI #5 had a physician's order for the oxygen, RN #23 looked at RI #5's Physician Orders and said yes. Surveyor asked RN #23 when the orders were initiated, she stated she helped LPN #22 input the orders earlier today. RN #23 stated nasal cannulas, nebulizer tubing and humidified water bottles should be changed weekly normally by the nurse on night shift. RN #23 said the tubing for the nasal cannula should be labeled with a date when changed.</p> <p>RI #52 was admitted to the facility on [DATE] with a diagnosis of Encounter For Screening for Respiratory Tuberculosis.</p> <p>RI #52's orders dated for 01/11/2024 documented, . Duoneb treatment tid, (three times a day) .</p> <p>On 06/11/2024 at 3:38 PM, RI #52's nebulizer machine was observed on the bedside table, the mask was uncovered, not in a plastic bag.</p> <p>On 06/12/2024 at 8:56 AM, RI #52's nebulizer machine was observed on the bedside table. The mask lying on bed side table, was uncovered, not in use, not in plastic bag.</p> <p>On 06/13/2024 at 11:28 AM, RI #52's mask was connected to nebulizer machine. The mask was uncovered, not in use, not stored in a plastic bag.</p> <p>On 06/13/2024 an interview was conducted with RN #15. RN #15 said the nebulizer mask should be stored in a zip locked bag when not in use. RN #15 stated the nurses who provide the treatment should make sure after they gave the treatment, the mask was stored in a plastic bag. When asked what was the concern with the nebulizer mask not being stored in a plastics bag, she stated an infection control issue.</p> <p>47408</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews, medical record reviews, and the facility policy titled Behavioral Health Services, the facility failed to ensure interventions were developed and implemented to address Resident Identifier (RI) #335's behaviors which included being physically and verbal aggressive towards staff and homicidal and suicidal ideation.</p> <p>On 06/23/2023, RI #335 was sent to the hospital emergency room after being physical and verbally abusive to staff and expressing homicidal and suicidal ideation.</p> <p>RI #335 returned from the hospital around 3:00 AM on 06/24/2023. The facility had not developed a plan for RI #335's return to ensure residents' safety. No new orders were provided, and no new interventions were developed or implemented.</p> <p>On 06/24/2023 around 4:30 AM, Certified Nursing Assistant (CNA) #27 witnessed RI #335 in RI #334's room. RI #335 was standing over RI #334's bed with a pillow over RI #334's face gripping both sides and pushing with force.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 443.40 Behavioral Health Services.</p> <p>On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings at the immediate jeopardy level in the area of Behavioral Health at F 740- Behavioral Health Services.</p> <p>The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>This deficiency was cited as a result of a Facility Reportable Investigation/Complaint/Report Number AL 00044582.</p> <p>This deficient practice affected one of four residents reviewed for behavioral health services.</p> <p>Findings Include:</p> <p>Cross reference F 600 and F 741.</p> <p>A review of a facility's policy titled, Behavioral Health Services, with an effective date of 10/02/2023 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Purpose:</p> <p>To ensure that residents receive necessary behavior health services.</p> <p>Policy:</p> <p>It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.</p> <p>Definitions:</p> <p>Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being.</p> <p>Highest practicable physical, mental and psychosocial well-being is defined as the highest possible level of functioning and well-being-limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, and psychosocial needs of the individual .</p> <p>Procedure: .</p> <p>3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.</p> <p>5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports base upon residents' individual needs, include, but are not limited to: .</p> <p>a. Depression- It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.</p> <p>e. Aggressive Behaviors-defined as behaviors that cause harm, threaten to harm, or put the health and safety of people risk .</p> <p>6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-center care .</p> <p>b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health;</p> <p>c. MDS and care area assessments;</p> <p>d. Ongoing monitoring of mood and behavior;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>e. Care plan development and implementation, and</p> <p>f. Evaluation.</p> <p>8. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment .</p> <p>9. Interventions shall be evidence-based, culturally competent, trauma-informed .</p> <p>RI #335 was admitted to the facility on [DATE] with diagnoses that included Dementia with Agitation and Major Depressive Disorder.</p> <p>A review of RI #335's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/08/2023, indicated RI #335's Brief Interview for Mental Status (BIMS) as five of 15, which indicated that RI #335 was cognitively impaired.</p> <p>A review of RI #335's care plan effective 09/21/2022 through 01/31/2023 included that RI #335 had wandering behaviors with interventions that included monitor his/her location to ensure safety. RI #335's care plan included the he/she had a history of paranoid statements about family taking items from her in a nursing home, has reported seeing men in living room at home when no home was present/seeing bugs on wall, hearing family members talking when they were not there, resident has threatened to kill his/her daughter and his/her family with interventions that included to remove from the situation. The care plan also included 9/28/22 Altercation with another resident. RI #335's care planned interventions did not indicate the level of supervision required.</p> <p>A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #30 and dated 06/23/2023 at 12:00 PM, revealed the following:</p> <p>. Called into the dining room by restorative cna and activities director. Was informed that this resident was going off and had thrown juice all over the staff and floor, saw staff wet clothes, and this resident standing near door. Walked up to resident and resident started telling activities director that this writer was in on it and then resident grabbed this nurse by the wrist and pulled this nurse toward him/her. This nurse pulled away from resident's grip and then resident began advancing toward this nurse . Was visibly angry and upset, would not leave dining room. Administrator walked in and was able to get him/her to leave . Before leaving, resident said, everyone in this room is going to get killed .</p> <p>On 06/13/2024 at 12:38 PM an interview was conducted with Restorative Certified Nursing Assistant (RCNA) #19. She described an incident that occurred during dining on 06/23/2023. She said, RI #335 was sitting at a table with two male residents and RI #335 was fixated on one male at the table. RCNA #19 stated she redirected the resident, and he/she got angry stood up and cursed. Then RI #335 grabbed a cup off another resident's plate and threw the juice cup. The resident threatened to do it again and grabbed another cup, but another staff intervene and was able to redirect him/her.</p> <p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:16 PM, revealed the following: resident stated he/she knows something is wrong in his/her head and feels that he/she would rather be gone then he/she hurt someone.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:59 PM, revealed the following: Stated that if he/she had a gun in front of him/her he/she would shoot himself/herself. Continue to make comments about get rid of me and I'm gonna do it.</p> <p>A review of RI #335's Clinical Notes Report entered by the Social Services Designee (SSD) dated 06/23/2023 at 1:32 PM, revealed the following: I sent information to (name of Psychiatric Facility) for resident's name RI #335 to go over there due to behavior. I was trying my best to get (him/her) next door instead of going to ER . I called (name of Mental Health Center) to see if they could speed up the process of getting him/her over there. No one responded, so they sent him/her to the ER .</p> <p>A review of RI #335's Clinical Notes Report entered by Registered Nurse (RN) #18 dated 06/24/2023, revealed the following: Resident brought by .to facility at 3 AM no new orders given . he/she did not know why he/she was sent to hospital</p> <p>The facility's investigative file included an undated witness statement from RI #188, a resident who was discharged at the time of the survey documented: . Resident stated the aggressor came in his/her room and was yelling and screaming leave him/her alone and don't touch him/her resident said the aggressor was talking to himself/herself. Resident said he/she was afraid because the aggressor was running in and out of his/her room and bathroom, so staff put a chair at the bathroom door to keep the aggressor from coming in through the bathroom.</p> <p>An undated witness statement from another resident, RI #33 documented: (typed) Did any resident come in your room last night? (handwritten) Yes, a female/male resident walked in to my room with a vase in his/her hand, walked in bathroom, and then CNA came and got him/her and walked him/her out. He/She was yelling, leave me alone .</p> <p>A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: . Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room. ADON (Assistant Director of Nursing) called the administrator and she said send him/her back to the (name of hospital) .</p> <p>The facility's investigative file included an undated written statement from CNA #27 documented: At approx (approximately) 4:30 AM I heard a door slam down 101 hall I went down the hall and checked in room and resident in room, so I walked through adjoining bathroom and noticed resident (RI #335) standing over . (RI #334) holding a pillow over his/her face/head. Resident was gripping pillow on both sides and pushing with force. (RI #335) was immediately removed from room . and was placed 1 to 1 with the nurse. The other nurse came . The resident (RI #334) . was ok .</p> <p>Unsuccessful attempts were made to interview CNA #27, the witness of the incident, on the phone several times during the survey.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table. RN #18 said she went to ask for help from another nurse and when she returned to the hall CNA #27 told her what happened.</p> <p>On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital, because he/she was not gone over 24 hours. RN #18 said between 3:00 AM and 4:30 AM, CNA #27 was walking the halls and saw RI #335 with the pillow over RI #334's face. She further stated, the CNA intervened and stopped RI #335, and RI #335 ran back to his/her room and the CNA followed. RN #18 said RI #335 picked up a statue in his/her room and tried to hit the CNA. RN #18 said, they were able to get RI #335 to the nurses' station to sit one to one and made sure RI #335 was away from other residents. The ADM and the DON were notified and the staff were instructed to remain one on one with him/her and he/she was sent back to the hospital.</p> <p>On 06/13/2024 at 10:10 AM an interview was conducted with Social Service Designee (SSD). The SSD stated, RI #335 became fixated on a male resident and began having behaviors, his/her mood would fluctuate, and he/she would really get upset and other times he/she would be calm. The SSD further said, RI #335 was aggressive toward other staff. RI #335 would always say, he/she could not get straight in her/his head and would hold his/her head. The SSD was asked what interventions did the facility implement for RI #335 behaviors. The SSD stated, she would walk RI #335 up to her office, allow RI #335 to sit with her and vent, and she got RI #335 involved in activities. The SSD was asked when did RI #335 start having aggressive behavior. She stated when he/she became attached to the male resident. When asked what interventions were put in place at that time. The SSD stated, RI #335 was moved to a different hall.</p> <p>On 06/15/2024 at 3:54 PM an interview was conducted with Social Services Designee. The SSD said that when RI #335 returned to the facility on Saturday, 06/24/2023, there were no interventions put in place, because the facility's staff did not know the hospital would send him/her back. The SSD said the facility thought the hospital would have kept him/her and they would have discussed his/her behavior and added interventions on Monday, 06/26/2023.</p> <p>On 06/13/2024 at 12:10 PM and interview was conducted with the Former Assistant Director of Nursing (FADON). The FADON was asked what actions/interventions were put in place as a result of the incident involving RI #335 on 06/23/2023. She stated she did not recall exactly. The FADON further stated RI #335 had been exhibiting behavior prior to the incident on 06/23/2023 which was impulsive and combative behavior but did not recall what psychiatric interventions were put in place.</p> <p>On 06/16/2024 at 12:46 PM an interview was conducted with the MDS Coordinator, RN. The MDS Coordinator (MDSC) was asked on 06/23/2024 when RI #335 was having behaviors, what interventions were developed and implemented. She said RI #335 was sent out to the hospital emergency room , but when RI #335 returned to the facility on [DATE], no interventions were added to his/her care plan.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 06/16/2024 at 1:04 PM a follow-up interview was conducted with the MDSC who said when RI #335 returned to the facility on [DATE] a nursing assessment was not done, but most likely should have been. The MDSC was asked, why was a nursing assessment not done on the resident upon return. The MDSC said the nursing notes indicated RI #335 was still combative and aggressive, so the staff might have not been able to do an assessment, but she was not sure. The MDSC said the facility did not put any interventions in place upon RI #335's return from the hospital on 06/24/2023. The MDSC said the facility should have put a plan or intervention in place. The MDSC said the concern with not having a plan or interventions in place was even though the hospital said he/she was cleared to return, the facility should have had a plan in place to try to prevent any further occurrence of aggressive behavior toward other residents for the safety of residents and staff.</p> <p>On 06/16/2024 at 4:13 PM an interview was conducted with the Director of Nursing (DON). The DON stated on 06/23/2023, RI #335 was sent to the hospital for physical aggressive behavior and suicidal ideation. The DON said the facility did not complete a nursing assessment when RI #335 returned to the facility on [DATE]. The DON said if a nursing assessment had been done, it would have triggered interventions such as one to one supervision. The DON was asked, what other interventions would you have expected to have been put in place. The DON said interventions for RI #335 and other residents' safety, so one on one supervision and notification of the supervisor, medical director, and resident's family that the resident was having suicidal ideations.</p> <p>*****</p> <p>On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which documented:</p> <p>Immediate Action Removal Plan for F 740</p> <p>Description:</p> <p>The facility failed to ensure interventions were developed and implemented to address RI#335's physical and verbally abusive behaviors towards staff and suicidal ideations.</p> <p>Safety:</p> <ol style="list-style-type: none"> 1. Resident #335 was redirected from the Dining room by the Administrator on 6/23/23 after yelling, throwing things and grabbing at staff. 2. Social services made referrals for Psych services on 6/23/23 related to physical and verbally abusive behaviors and suicidal ideation. Charge Nurse sent RI #335 to the ER on [DATE] and transported by HEMS. 3. Resident #335 returned from the hospital by HEMS on at 3 am on 6/24/23 with no new orders. Labs were drawn at the ER. Per ER records resident denied any complaints, denied suicidality and homicidal ideations. 4. Resident's #334 and #335 were separated by the CNA on 6/24/23. <p>Assessments:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted. 2. On 6/26/23 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings. 3. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMS and ultimately discharged . 4. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 6/24/23 with no negative findings. 5. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 6/24/23 with no negative findings. 6. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 6/24/23 by the Administrator. 7. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 6/11/24 and 6/18/24 with no negative findings. 8. Residents with a BIMS of 12 or less, a body audit and observation for abuse and behaviors was completed by the Director of Nursing, Staffing Coordinator, and Charge Nurse on 6/11/24 with no negative findings. 9. Resident interviews using a Resident Psychosocial Health Questionnaire were conducted by Social Services Director with BIMS of 13 or greater to determine resident's mood, behaviors, and thoughts such as anxiety, agitation, depression, suicidal and homicidal ideations on 6/18/2024, with no new negative findings. <p>Notification:</p> <ol style="list-style-type: none"> 1. On 6/24/23 Charge Nurse made notifications to the practitioners and responsible parties for resident #334 and #335. <p>Audits:</p> <ol style="list-style-type: none"> 1. Clinical Record Review from 3/1/24 to 6/16/24 was initiated on 6/16/24 and completed on 6/17/2024 by the Director of Clinical Education and Regional Nurse Managers to include clinical notes, event notes, and daily skilled notes to identify any potential residents for instances of allegations of potential/actual abuse, aggressive, distress, and combative behaviors, and suicidal and homicidal ideations, with no new unknown findings. <p>In-services:</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. On 6/16/24 Inservice was provided by the Assistant [NAME] President of Operations and the Regional Nurse Manager to the Administrator, DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress and combative behaviors, and suicidal/homicidal ideation. Education was also provided regarding staff unavailable to receive education will not be permitted to work until required education is completed.</p> <p>The Staffing Coordinator was designated as responsible for ensuring staff are educated n abuse prohibition plan, behavioral health services policy, and list of interventions for behaviors</p> <p>2. On 6/16/24 Inservice was provided by the DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behaviors, and suicidal/homicidal ideation to all staff. Staff unavailable to receive education will not be permitted to work until the required education is completed. 73 out of 77 employees have been educated.</p> <p>3. On 6/16/2024 competency and validation questions were answered by staff currently working to ensure competency verbalized from education received.</p> <p>4. On 6/17/2024 the Regional Nurse Manager placed signage in break rooms, nurses stations, and behavior communication binders that list interventions for behaviors including abuse, aggressive, distress and combative behaviors, and suicidal/homicidal ideation. This communication binder is used as a communication tool for staff to note resident behaviors, new or changes. This communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine appropriate interventions.</p> <p>5. On 6/18/2024 Regional Nurse Manager inserviced the DON, Staffing Coordinator and Risk Manager that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations.</p> <p>6. On 6/18/2024 the DON, Staffing Coordinator, and Risk Manager in-serviced Nursing Staff that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated.</p> <p>QAPI:</p> <p>1. Adhoc QAPI was conducted on 6/24/23 to include Administrator, Director of Nursing, Senior [NAME] President of Operations, Assistant [NAME] President of Operations, Regional Nurse Manager, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager to discuss resident to resident altercation event, education, root cause, and interventions.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. The Medical Director was notified of the immediate jeopardy citations on 6/16/24 by the Assistant [NAME] President of Operations.</p> <p>3. A Root cause analysis was conducted on 6/16/24 by the Administrator, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Directors of Nursing, Assistant [NAME] President of Quality, Director of Clinical Education. Root cause was identified as ineffective training and education related to behavioral health services.</p> <p>4. QAPI meeting was conducted on 6/16/24 to include Administrator, Director of Nursing, Staffing Coordinator, Dietary Manager, Activity Coordinator, Treatment Nurse, Receptionist, MDS Coordinator, Social Service Director, Business Office Manager, Maintenance Director, Regional Nurse Manage, Assistant [NAME] President of Operations, Regional Nurse Manager, Medical Director, Assistant [NAME] President of Clinical Operations, Senior [NAME] President, and Director of Clinical Education regarding Immediate Jeopardy citations, Abuse and Behavior Health Services policy review, education, interventions for immediate removal plan, Medical Director notification, facility assessment updated/reviewed and root cause analysis determined.</p> <p>a. Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideations (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services.</p> <p>b. Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, and combative behaviors, and Suicidal and Homicidal Ideations.</p> <p>c. The facility assessment plan was revised to include suicidal ideations.</p> <p>5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9pm to discuss the corrective action plans to address the immediate concerns for F 600, F 740, F 741 and F 867 for Resident's #334 and #335 and all current residents in the facility have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations.</p> <p>6. This Behavior Communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine any new or changes in behaviors, intervention implementation and appropriateness and will be revised as necessary.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7. Upon return from a transfer when ER deems resident appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a Resident Return from Transfer Behavior assessment will be conducted. This will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. For any resident discharged and readmitted a readmission assessment is already part of the readmission process and is completed to include an abuse and behavior section. On 6/18/2024 Nursing Staff was educated that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated.</p> <p>Facility implemented all corrective actions by 6/18/2024.</p> <p>*****</p> <p>After a review of documentation supporting the above corrective actions, including the facility's investigative file, in-service/education records, QAPI documentation, and staff interviews, the survey team verified the facility implement corrective actions including ongoing monitoring on 06/18/2024.</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33738</p> <p>Based on interviews, record review, and a review of a policy titled, Behavioral Health Services, the facility failed to ensure there were sufficient staff who had the knowledge, training, competencies, and skills sets to address the behavioral health care needs of Resident Identifier (RI) #335 after RI #335 was sent to the hospital for aggressive behaviors and suicidal and homicidal ideations. The facility did not develop and implement interventions to ensure resident's safety or to provide additional supervision.</p> <p>On 06/23/2023 during lunch, RI #335 was physically and verbally abusive to staff and had suicidal and homicidal ideation before being sent to the hospital.</p> <p>Upon return from the hospital on 06/24/2023 around 3:00 AM, the facility did not ensure interventions were developed and implemented to ensure residents' safety or to provide additional supervision.</p> <p>Staff identified that RI #335 was acting strange, she was not being herself, she was not being cooperative, she would not listen to what staff were saying when she was redirected to her room as she previously had done. No actions were taken to ensure residents' safety. Around 4:30 AM, RI #335 was witnessed by a CNA in RI #334's room, standing over RI #334's bed with a pillow over RI # 334's face gripping both sides and pushing with force.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.40 Behavioral Health at F 741-Sufficient/Competent Staff-Behavior Health Needs.</p> <p>On 06/16/2024 at 6:56 PM, the Administrator, Assistant [NAME] President of Operations, Regional Nurse Manager, and the Director of Nursing (DON) were provided the IJ templates and notified of the findings at the immediate jeopardy level in the area of Behavioral Health Services at F 741-Sufficient/Competent Staff-Behavior Health Needs.</p> <p>The IJ began on 06/24/2023 and continued until 06/18/2024 when the survey team verified onsite that corrective actions had been implemented. On 06/19/2024, the immediate jeopardy was removed, and was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.</p> <p>This deficiency was cited as a result of a Facility Reportable Investigation complaint/report number AL00044582.</p> <p>This deficient practice affected one of four residents reviewed for behavioral health services.</p> <p>Findings Include:</p> <p>Cross Reference F 600 and F 740.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Purpose: To ensure that residents receive necessary behavior health services.</p> <p>Policy: It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning.</p> <p>Definitions: Definitions are provided to clarify terminology related to behavioral health services and the attainment or maintenance of a resident's highest practicable well-being. Highest practicable physical, mental and psychosocial well-being is defined as the highest possible level of functioning and well-being-limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, and psychosocial needs of the individual .</p> <p>Procedure: .</p> <p>3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.</p> <p>5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports base upon residents' individual needs, include, but are not limited to: .</p> <p>a. Depression- It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.</p> <p>e. Aggressive Behaviors-defined as behaviors that cause harm, threaten to harm, or put the health and safety of people risk .</p> <p>6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-center care .</p> <p>b. Obtaining history from medical records, the family, and the resident regarding mental, psychosocial, and emotional health;</p> <p>c. MDS and care area assessments;</p> <p>d. Ongoing monitoring of mood and behavior;</p> <p>(continued on next page)</p>

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>e. Care plan development and implementation, and</p> <p>f. Evaluation.</p> <p>8. Facility staff shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the employee and needs identified through the facility assessment .</p> <p>9. Interventions shall be evidence-based, culturally competent, trauma-informed .</p> <p>RI #335 was admitted to the facility on [DATE] with diagnoses that included Dementia with Agitation and Major Depressive Disorder.</p> <p>A review of RI #335's Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 05/08/2023, indicated RI #335's BIMS (Brief Interview for Mental Status) was five of 15 which indicated that RI #335 was cognitively impaired.</p> <p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:16 PM, revealed the following: resident stated he/she knows something is wrong in his/her head and feels that would rather be gone then he/she hurt someone</p> <p>A review of RI #335's Clinical Notes Report entered by RN #30 dated 06/23/2023 at 12:59 PM, revealed the following: Stated that if he/she had a gun in front of him/her he/she would shoot himself/herself. Continue to make comments about get rid of me and I'm gonna do it.</p> <p>A review of RI #335's Clinical Notes Report entered by the Social Services Designee (SSD) dated 06/23/2023 at 1:32 PM, revealed the following: I sent information to (name of Psychiatric Facility) for resident's name RI #335 to go over there due to behavior. I was trying my best to get (him/her) next door instead of going to ER .I called (name of Mental Health Center) to see if they could speed up the process of getting him/her over there. No one responded, so they sent him/her to the ER .</p> <p>The local hospital's ED Note Physician documented that RI #335 was admitted on [DATE] at 1:48 PM and discharged on [DATE] at 2:45 AM. RI #335 was seen by the medical doctor at the hospital on 06/23/2023 at 2:29 PM. The note included:</p> <p>. History of Present Illness .</p> <p>. presents for evaluation of aggressive behavior . he/she made some suicidal homicidal thoughts .</p> <p>Medical Decision Making</p> <p>I reached out to staff at Millenium health to discuss the case. They said that his/her behavior is certainly progressing worsening over the last few weeks and is the first time he/she has been physically assaultive with staff at the facility. He/she then also stated that he/she was going to kill everyone and that something was wrong with him/her and the he/she wanted to kill himself/herself. He/She is obviously denying all of this here . likely disposition back to the facility .</p> <p>A review of RI #335's Clinical Notes Report dated 06/24/2023, revealed the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Ahc Millenium		STREET ADDRESS, CITY, STATE, ZIP CODE 5275 Millennium Drive Huntsville, AL 35806	
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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident brought by .to facility at 3 AM no new orders given .</p> <p>A review of RI #335's Clinical Notes Report entered by RN #18 dated 06/24/2023 at 5:33 AM, revealed the following: . Resident came back from (name of hospital) went into 200 hall being combative going into other resident rooms, brought him/her back to 100 he/she tried to hit CNA with the hole puncher he/she kept saying we are going to hell and CNA is dead and he/she took a statue from his/her room and tried to hit us with it he/she was throwing the snack tray around trying to hit the nurse. He/She tried to hit the CNA with the pill crusher, he/she tried to smother another resident with a pillow the CNA walked in on him/her and he/she tried to run back to his/her room .</p> <p>On 06/13/2024 at 1:00 PM during an interview, Registered Nurse (RN) #18 stated on the night of the incident, RI #335 was acting strange and was not acting like himself/herself. RN #18 said RI #335 was uncooperative and would not go to his/her room. RN #18 said when RI #335 was asked to go to his/her room, RI #335 got mad and pushed all the snacks off the table. RN #18 said she went to ask for help from another nurse and when she returned to the hall CNA #27 told her what happened.</p> <p>On 06/13/2024 at 6:20 PM a follow-up interview was conducted with RN #18 who said a nursing assessment was not completed when RI #335 returned from the hospital, because he/she was not gone over 24 hours.</p> <p>On 06/14/2024 at 6:52 PM an interview was conducted with the MDS Coordinator (MDSC). The MDSC was asked what training have staff received about residents with suicidal ideation. She said she did not know exactly when they had education or training on suicidal ideation.</p> <p>On 06/16/2024 at 4:13 PM was conducted with the Director of Nursing (DON). The DON stated when RI #335 returned from the hospital on 06/24/2023 a nursing assessment was not completed on resident. She further stated RI #335, was sent to the hospital for physical aggressive behavior and suicidal ideation should have had an assessment completed when he/she returned to the facility. The DON said if a nursing assessment had been done, it would have triggered interventions such as one to one supervision. The DON was asked, what other interventions would you have expected to have been put in place. The DON said interventions for RI #335 and other residents' safety, so one on one supervision and notification of the supervisor, medical director, and resident's family that the resident was having suicidal ideations.</p> <p>In a follow up interview with the MDSC on 06/16/2024 at 12:46 PM, she was asked, when RI #335 returned from the hospital on 06/24/2023 was a nursing assessment completed. The MDSC said, no there was not a nursing assessment done on RI #335, but a nursing assessment should have been done. According to the RI #335's progress notes, when RI #335 returned from the hospital on 06/24/2023 she was still combative and aggressive, did the facility add any interventions or put a plan in place. The MDSC stated, there were no interventions or plan put in place but interventions or a plan should have been put in place. When asked what would be the concern of not having a plan or interventions in place for a resident with aggressive behavior or suicidal ideation. She said the facility should have had a plan in try to prevent any further occurrence of aggressive behavior toward other residents and for the safety of residents and staff. The MDSC was asked did the facility provide training/education on how to manage resident with aggressive behavior and suicidal thoughts, where was the documentation. The MDSC stated she would have to check.</p> <p>*****</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 06/18/2024 at 6:00 PM, the facility submitted an acceptable removal plan, which document:</p> <p>Description;</p> <p>On 6/24/23 Resident #335 was observed standing over RI #334's bed with pillow over face gripping both sides with force.</p> <p>Safety:</p> <ol style="list-style-type: none"> 1. Resident #335 was redirected from the Dining room by the Administrator on 6/23/23 after yelling, throwing things and grabbing at staff. 2. Social services made referrals for Psych services on 6/23/23 related to physical and verbally abusive behaviors and suicidal ideation. Charge Nurse sent R1#335 to theER on [DATE] and transported by HEMSI. 3. Resident #335 returned from the hospital by HEMSI on at 3am on 6/24/23 with no new orders. Labs were drawn at the ER. Per ER records resident denied any complaints, denied suicidally and homicidally. 4. Resident's #334 and #335 were separated by the CNA on 6/24/23. <p>Assessment:</p> <ol style="list-style-type: none"> 1. Resident #334 was assessed by the Charge Nurse on 6/24/23, with no injuries noted. 2. On 6/26/23 the Psychiatric Nurse Practitioner assessed Resident #334 and documented in a provider note with no negative findings. On 6/26/23 Resident #334 was assessed by the Nurse with no negative findings. 3. Resident #335 was placed on one on one by the Charge Nurse on 6/24/23 until resident transferred to the hospital by HEMSI and ultimately discharged . 4. Resident interviews were conducted by the Social Services Director and Activity Coordinator with a BIMS of 13 or greater regarding physical or verbal abuse by another resident on 6/24/23 with no negative findings. 5. Residents with a BIMS of 12 or less, a body audit was completed by the Director of Nursing and Charge Nurse on 6/24/23 with no negative findings. 6. Alabama Department of Health, Adult Protective Services, and law enforcement were notified of the reported events on 6/24/23 by the Administrator. 7. Resident interviews were conducted by the Social Services Director with a BIMS of 13 or greater regarding abuse by anyone on 6/11/24 and 6/18/2024 with no negative findings. <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>8. Residents with a BIMS of 12 or less, a body audit and observation for abuse and behaviors was completed by the Director of Nursing, Staffing Coordinator, and Charge Nurse on 6/11/24 with no negative findings.</p> <p>9. Resident interviews using a Resident Psychosocial Health Questionnaire were completed by Social Services Director with BIMS of 13 or greater to determine resident's mood, behaviors and thoughts such as anxiety, agitation, depression, suicidal and homicidal ideation on 6/18/2024, with no new negative findings.</p> <p>Notification:</p> <p>1. On 6/24/23 Charge Nurse made notifications to the practitioners and responsible parties for resident #334 and #335.</p> <p>Audits:</p> <p>1. Clinical Record Review from 3/1/24 to 6/16/24 was initiated on 6/16/24 and completed on 6/17/2024 by the Director of Clinical Education and Regional Nurse Managers to include clinical notes, event notes, and daily skilled notes to identify any potential residents for instances of potential/actual abuse, aggressive, distress, and combative behaviors, and suicidal and homicidal ideation that might require Behavioral Health services, with no new unknown findings.</p> <p>In-services:</p> <p>1. On 6/16/24 Inservice was provided by the Assistant [NAME] President of Operations and the Regional Nurse Manager to the Administrator, DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, updated Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behaviors and suicidal/homicidal ideation. Education was also provided regarding staff unavailable to receive education will not be permitted to work until required education is completed.</p> <p>The Staffing Coordinator was designated as responsible for ensuring staff are educated n abuse prohibition plan, behavioral health services policy, and list of interventions for behaviors</p> <p>2. On 6/16/24 Inservice was provided by the DON, Staffing Coordinator, Social Services, and Receptionist/CNA on the Abuse Policy Protocol, Behavior Health Services Policy, and interventions related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideation to all staff. Staff unavailable to receive education will not be permitted to work until the required education is completed. 73 out of 77 employees have been educated.</p> <p>3. On 6/16/2024 competency and validation questions were answered by staff currently working to ensure competency verbalized from education received.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>4. On 6/17/24 the Regional Nurse Manager placed signage in break rooms, nurses stations, and behavior communication binders that list interventions for behaviors including abuse, aggressive, distress, and combative behaviors, and suicidal/homicidal ideation. This communication binder is used as a communication tool for staff to note resident behaviors, new or changes. This communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine appropriate interventions.</p> <p>5. On 6/18/2024 Regional Nurse Manager inserviced the DON, Staffing Coordinator and Risk Manager that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideation's a behavioral assessment should be conducted. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideation's.</p> <p>6. On 6/18/2024 the DON, Staffing Coordinator, and Risk Manager inserviced Nursing Staff that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideation a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideation. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated.</p> <p>QAPI:</p> <p>1. Adhoc QAPI was conducted on 6/24/23 to include Administrator, Director of Nursing, Senior [NAME] President of Operations, Assistant [NAME] President of Operations, Regional Nurse Manager, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager to discuss resident to resident altercation event, education, root cause, and interventions.</p> <p>2. The Medical Director was notified of the immediate jeopardy citations on 6/16/24 by the Assistant [NAME] President of Operations.</p> <p>3. A Root cause analysis was conducted on 6/16/24 by the Administrator, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Directors of Nursing, Assistant [NAME] President of Quality, Director of Clinical Education. Root cause was identified as ineffective training and education related to behavioral health services.</p> <p>4. QAPI meeting was conducted on 6/16/24 to include Administrator, Director of Nursing, Staffing Coordinator, Dietary Manager, Activity Coordinator, Treatment Nurse, Receptionist, MDS Coordinator, Social Service Director, Business Office Manager, Maintenance Director, Regional Nurse Manage, Assistant [NAME] President of Operations, Regional Nurse Manager, Medical Director, Assistant [NAME] President of Clinical Operations, Senior [NAME] President, and Director of Clinical Education regarding Immediate Jeopardy citations, Abuse and Behavior Health Services policy review, education, interventions for immediate removal plan, Medical Director notification, facility assessment updated/reviewed and root cause analysis determined.</p> <p>a. Abuse Prohibition Plan reviewed with no recommendation for changes 6/16/24</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b. Behavior Health Services Policy reviewed with recommendation made to include suicidal and homicidal ideations (Section 5, Subset F) under procedures- to include risk factors, triggering events, examples used to harm self. Definition of Suicidal Ideation added to provide clarification of terminology related to behavioral health services.</p> <p>c. Updated Intervention list attachment included in the updated Behavior Health Policy for behaviors to include immediate action steps to implement related to abuse, aggressive, distress, and combative behavior, and Suicidal and Homicidal Ideations.</p> <p>d. The facility assessment plan was revised to include suicidal ideations.</p> <p>5. A Governing Body meeting was held to include the Administrator, Director of Nursing, Assistant [NAME] President of Operations, Assistance [NAME] President for Clinical, Senior [NAME] President of Operations, and Regional Nurse Managers on 6/16/24 at 9pm to discuss the corrective action plans to address the immediate concerns for F600, F740, F741, and F867 for Resident's #334 and #335 and all current residents in the facility have the potential to be affected. The Medical Director agreed with the current action plan and had no new recommendations</p> <p>6. This Behavior Communication binder is brought to morning QA by a member of the Behavior Committee and reviewed during QA to determine any new or changes in behaviors, intervention implementation, and appropriateness and will be revised as necessary.</p> <p>7. Upon return from a transfer when ER deems resident appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a Resident Return from Transfer Behavior assessment will be conducted. This will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. For any resident discharged and readmitted a readmission assessment already part of the readmission process is completed to include an abuse and behavior section. On 6/18/2024 Nursing Staff educated that upon return from a transfer when ER deems residents appropriate for return for residents sent out related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations a behavioral assessment should be conducted using the Resident Return from Transfer Behavior assessment form. This form will help us determine if behaviors are present and require interventions upon return to the facility after a transfer related to abuse, aggressive, distress, and combative behavior, and suicidal/homicidal ideations. Nursing Staff unavailable to receive education will not be permitted to work until the required education is completed. 20 out of 22 Nurses have been educated.</p> <p>Facility implemented all corrective actions by 6/18/2024.</p> <p>*****</p> <p>After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QAPI documentation, and staff intervention, the survey team verified the facility implemented corrective actions including ongoing monitoring on 06/18/2024.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>20304</p> <p>Based on observation, interview, the facility's policy for Dietary: Menus and Adequate Nutrition, the facility's 2024 S/S (Spring/Summer) Week 2 Menu, the facility's posted Dish Capacity guide, and the facility's recipes for Salisbury Steak, Seasoned [NAME] Beans, Chicken Fettuccini Alfredo, and Buttered Noodles; the facility failed to ensure the residents received nutrition as planned per the facility's menu by allowing the following:</p> <p>hot water was added to puree food items during Lunch service on 06/12/2024 to extend the volume available,</p> <p>the amounts of Chicken [NAME] and of Noodles served for the Regular, Mechanical Soft, Dysphagia II, and Puree/Dysphagia I texture diets were less than the amounts indicated on the menu for Lunch on 06/13/2024, and</p> <p>orange slices were served to most of the residents receiving Consistent Carbohydrate (CCHO) diets, instead of apple slices as indicated by the menu for Lunch on 06/13/2024.</p> <p>This had the potential to affect all residents receiving Regular, Mechanical Soft, Dysphagia II (Dys II), and Puree/Dysphagia I (Dys I) texture diets and residents receiving CCHO diets from the facility's kitchen; 79 of 79 residents.</p> <p>Findings include:</p> <p>The facility's policy for Dietary: Menus and Adequate Nutrition, revised 07/31/2023, included the following:</p> <p>. Purpose:</p> <p>The purpose of this policy is to assure menus are developed and prepared, based on reasonable efforts, to meet resident choices and reflect the resident's nutritional . needs, while using established guidelines .</p> <p>Policy:</p> <p>1. The community shall ensure that menus:</p> <p>a. Meet the nutritional needs of resident in accordance with established national guidelines .</p> <p>c. Be followed .</p> <p>On 06/12/2024, the facility's 2024 S/S (Spring/Summer) Menu for Week 2, Wednesday, Lunch was observed to have the following change approved by the Registered Dietitian (RD): Salisbury Steak instead of Country Fried Steak. The menu therefore indicated the Pureed/Dys I diet was to receive 3 oz. (ounces) Pureed Salisbury Steak with Gravy and 4 oz. Pureed [NAME] Beans in addition to other items.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's recipe for Salisbury Steak - 4102 included the following: . Service portion: 1 (one) 3oz steak patty . Puree Steps: Remove desired number of servings and add nutritive liquid, milk, broth, etc. (to indicate further, similar items are included). Blend until desired consistency. Add approved thickener to achieve desired consistency if needed.</p> <p>The facility's recipe for Seasoned [NAME] Beans - 1038 included the following: . Service portion: 4oz (#8 scoop/disher). Puree Steps: Remove desired number of servings and add nutritive liquid, milk, broth, etc. Blend until desired consistency. Add approved thickener to achieve desired consistency if needed.</p> <p>On 06/12/2024 at 11:07 AM, the facility's trayline was ongoing for lunch with the AM [NAME] serving the residents' meal plates. At 11:20 AM, observed Salisbury Steak on the steamtable (being substituted for the Country Fried Steak and indicated as approved by the RD by her initials on the menu posted at the steamtable). There were two observations of the puree meat scoop not being filled completely for service. Then an observation of hot water being added to the puree meat and stirred in by AM Cook. Then a third observation of the scoop not being fully filled with puree meat. At 11:55 AM, there was an observation of hot water being added to the puree green beans by the AM Cook. There were still not enough puree green beans for a serving and it looked more liquid than puree. The Kitchen Supervisor began preparing additional puree green beans. At 12:02 PM, the Lunch trayline service was finished.</p> <p>On 06/13/2024, the facility's 2024 S/S (Spring/Summer) Menu for Week 2, Thursday, Lunch included the following:</p> <p>Regular and CCHO diets were to receive 6 oz Chicken Fettuccini [NAME] and 4 oz Buttered Noodles,</p> <p>Mechanical Soft diets were to receive 6 oz Gr (Ground) Chicken [NAME] and 4 oz Buttered Noodles,</p> <p>Dys II, and Puree/Dys I texture diets were to receive 6 oz Pur (Pureed) Chicken [NAME] and 4 oz Pur Buttered Noodles, and</p> <p>CCHO diets were to receive 4 oz Apple Slices.</p> <p>The facility's recipe for Chicken Fettuccini [NAME] - 4238 included the following: . Service portion: 6 oz Chicken Fettuccini Alfredo. 3oz (#10 scoop) Pasta & [and] 3oz (3-4 strips) Chicken .</p> <p>The facility's recipe for Buttered Noodles - 2005 included the following: . Service portion: 4 ounces .</p> <p>On 06/13/2024 at 10:33 AM, Diet Aide #16 was observed portioning Apple Pie for the residents' Lunch. Diet Aide #16 said the CCHO were getting fresh orange slices. Diet Aide #16 said the CCHO (diets) do not get a lot of sugar, so they get fresh fruit. Diet Aide #16 further said one person had a sliced fresh apple because the resident cannot eat oranges. Observed servings of fresh orange slices and one serving of fresh apple slices.</p> <p>On 06/13/2024 at 10:47 AM, a Disher [scoop] Capacity chart was observed on the bulletin board in the Kitchen over the Prep Sink, which included the following:</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>[NAME] #6 disher equals 4.66 fluid ounces</p> <p>Grey #8 disher equals 3.64 fluid ounces</p> <p>[NAME] #12 disher equals 2.78 fluid ounces</p> <p>On 06/13/2024 at 10:54 AM, the AM [NAME] began putting pans on the steamtable for lunch service. At 11:33 AM, trayline temperatures were being checked and the following was observed:</p> <p>Two full pans of Chicken (in chunks) and Noodles mixed together with [NAME] Sauce and a 4-ounce serving spoodle,</p> <p>Mechanical Soft Chicken and Noodles mixed together with [NAME] Sauce and a 4-ounce serving spoodle,</p> <p>Chicken and Noodles and [NAME] Sauce pureed together with a #6 scoop/disher.</p> <p>Trayline service was observed until 12:09 PM, when the last serving cart was loaded.</p> <p>On 06/13/2024 at 12:34 PM, the Kitchen Supervisor was interviewed:</p> <p>The Kitchen Supervisor was given the facility's 2024 S/S (Spring/Summer) Menu for Week 2, Thursday, Lunch to review as needed. When asked how much Chicken Fettuccini [NAME] was supposed to be served per the menu, the Kitchen Supervisor said 6 ounces. When asked how much Buttered Noodles was supposed to be served per the menu, the Kitchen Supervisor said 4 ounces. The Kitchen Manager was reminded that the Chicken Fettuccini [NAME] was mixed with the Noodles and a 4 oz. spoodle was used to serve the combined items. When asked how much should have been served per portion since the two menu items were mixed together, the Kitchen Supervisor said 10 ounces. The Kitchen Manager then said there is no 10-ounce ladle or spoodle. When asked what could have been done, the Kitchen Supervisor said, I would use the closest scoop/spoodle size. We have an eight-ounce spoodle, I think. But it still would not be the right amount. When asked if the Mechanical Soft Chicken [NAME] mixed with Noodles and served with the 4 oz. spoodle was enough, the Kitchen Manager said no, it was not enough. The Kitchen Manager further said it should be separated into noodles and the chicken with sauce. When asked if the pureed Chicken [NAME] mixed with Noodles served with the #6 scoop/disher was enough, the Kitchen Manager said no. The Kitchen Manager said not serving the amount as indicated on the menu meant the residents are not getting enough food. When asked why sliced oranges were served to the residents at lunch instead of sliced apples; the Kitchen Manager said we have apples, I do not know why.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Ahc Millenium		STREET ADDRESS, CITY, STATE, ZIP CODE 5275 Millennium Drive Huntsville, AL 35806	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/13/2024 at 1:08 PM, the AM [NAME] was interviewed: The AM [NAME] was asked why she was adding hot water to the puree food at lunch yesterday (Wednesday, 6/12/2024). The AM [NAME] replied, To stretch it. The AM [NAME] said she asked her manager (the Dietary Manager) this morning if the Chicken [NAME] was to be mixed with the Noodles and she said yes. The AM [NAME] agreed that a 4 oz. spoodle was used to serve the Chicken Fettuccini [NAME] mixed with the Noodles. The AM [NAME] was given the facility's 2024 S/S (Spring/Summer) Menu for Week 2, Thursday, Lunch to review as needed. When asked how much Chicken Fettuccini [NAME] should be served per person according to the menu, the AM [NAME] said 6 ounces. When asked how much Buttered Noodles should be served per person according to the menu, the AM [NAME] said 4 ounces. When asked how much should have been a serving since the Chicken Fettuccini [NAME] and Buttered Noodles were mixed together, the AM [NAME] said 10 ounces. The AM [NAME] then said there was not a 10-ounce spoodle. When asked what could have been done, the AM [NAME] said she did not know. When asked if the 4 oz. spoodle used to serve the Mechanical Soft Chicken [NAME] mixed with Noodles was enough for a serving, the AM [NAME] said it should have been 10 ounces. When asked if the #6 scoop/disher used to serve the pureed Chicken [NAME] mixed with Noodles was enough for a serving, the AM [NAME] said it should have been 10 ounces.</p> <p>On 06/13/2024 at 5:31 PM, the Dietary Manager was interviewed: When asked what instructions were given to food service employees for preparing pureed foods properly and in adequate quantity, the Dietary Manager said they were shown when they were trained for the position. The Dietary Manager said it was not acceptable to add hot water to a pureed food during meal service to stretch it. The Dietary Manager said the problem was diluting the food and reducing the nutrients. When asked how the food service employees knew how much to serve of each food item, the Dietary Manager said they have the menus with portion sizes, spoodles in different ounce capacities, and have color-coordinated scoops/dishers, and a chart. The Dietary Manager said Corporate (the corporate office) developed and approved the menus used at the facility. The Dietary Manager said she had received consultations from the Registered Dietitian two Tuesdays out of the month so far and topics had included temperatures, food dating, cleanliness, organization, portion sizes, and menu items in house. The Dietary Manager was given the facility's 2024 S/S (Spring/Summer) Menu for Week 2, Thursday, Lunch to review as needed. It was noted that the menu listed 6 ounces Chicken Fettuccini [NAME] and 4 ounces Buttered Noodles as separate menu items, but the Chicken Fettuccini [NAME] and the Noodles were mixed together in pans for service on the trayline. When asked if the 4 oz. spoodle used to serve the Chicken Fettuccini [NAME] mixed with Noodles to the Regular Diets was a large enough portion, the Dietary Manager said no. When asked if the Mechanical Soft Chicken [NAME] mixed with Noodles and served with the 4 oz. spoodle was enough, the Dietary Manager said no. When asked if the #6 scoop/disher used to serve the pureed Chicken [NAME] mixed with Noodles was enough for a serving, the Dietary Manager said no. When asked the concern for residents, the Dietary Manager said that the residents were not getting enough food, protein, nutrients. The Dietary Manager said fresh apples were available in the kitchen the night before and that morning. When asked why would staff not serve sliced apples to the CCHO diets per the menu today (Thursday, 06/13/24), the Dietary Manager said they might not have had knowledge of the apples. The Dietary Manager said she did not ask the RD to approve a change from apples to oranges.</p> <p>On 06/13/2024 at 7:20 PM, the Registered Dietitian (RD) was interviewed by phone:</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>When asked what instructions were given to food service employees for preparing pureed foods properly and in adequate quantity, the RD said it should be on the recipe. The RD said it would not be acceptable for the [NAME] to add hot water to a pureed food during meal service to stretch it. When asked the problem; the RD said the calories would not be the same, as there would be fewer calories per serving. The RD further said it could also change the consistency. When asked how the food service employees know how much to serve of each food item, the RD said the portions are on the menus and in the recipes. The RD further said the size of dishes/scoops to use for specific serving sizes (ounces) should be on the recipe. The RD was told that according to the Week 2 menu for Thursday, 6 ounces Chicken Fettuccini [NAME] was supposed to be served over 4 ounces Buttered Noodles, but the Chicken Fettuccini [NAME] and the Noodles were mixed together in a pan for service on the trayline. When told that a 4 oz. spoodle was used to serve the Chicken Fettuccini [NAME] mixed with Noodles to the Regular Diets, the RD said that was not enough. When told a 4 oz. spoodle was used for the serving the Mechanical Soft Chicken [NAME] mixed with Noodles, the RD said that was not enough. When told a #6 scoop/disher was used to serve the pureed Chicken [NAME] mixed with Noodles, the RD said that was not enough. When asked the concern for residents, the RD said the menus were prepared to provide serving sizes to meet the residents' caloric needs. The RD said she was not asked to approve serving oranges to the CCHO diets instead of sliced apples for lunch on Thursday, 06/13/2024.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20304</p> <p>Based on observation, interview, the facility's Dish Machine Temperatures-Sanitation log for June 2024, the facility's policies for Dietary- Mechanical Dishwashing and Dietary- Hand Washing Techniques, and the 2022 United States (U.S.) Food and Drug Administration (FDA) Food Code; the facility failed to prevent cross-contamination on 06/11/2024 by allowing the following to occur:</p> <p>Staff going from handling dirty dishes to handling clean dishes and not washing their hands,</p> <p>Staff using a cloth to dry multiple wet trays instead of air drying,</p> <p>Access to a hand sink was blocked by a plate lowerator and when staff reached over the equipment to use the hand sink, water splashed onto the stored plates, and</p> <p>Staff chewing gum in the kitchen.</p> <p>The facility further failed to ensure sanitizing of dishware by not checking the dish machine temperatures prior to washing breakfast dishes on 06/11/2024, by the dish machine final rinse not reaching the minimum temperature of 180 (degrees) Fahrenheit (F) on 06/11/2024, and by not recording actual temperatures on the dish machine temperature log.</p> <p>This had the potential to affect all residents receiving meals from the facility's kitchen, 79 of 79 residents.</p> <p>Findings include:</p> <p>The 2022 U.S. FDA Food Code included the following:</p> <p>. 2-4 Hygienic Practices</p> <p>2-401 Food Contamination Prevention</p> <p>2-401.11 Eating, Drinking, or Using Tobacco Products</p> <p>(A) . an EMPLOYEE shall eat, drink, or use any form of TOBACCO PRODUCTS only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection can not result.</p> <p>[Annex 2, page 22:</p> <p>. 2-401.11 Eating, Drinking, or Using Tobacco Products.</p> <p>2-402.11 Effectiveness.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) . (8) 'Confining .eating food, chewing gum, drinking beverages or using tobacco.']</p> <p>. 2-301.14 When to Wash.</p> <p>FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with . clean EQUIPMENT and UTENSILS, . and: .</p> <p>(E) After handling soiled EQUIPMENT or UTENSILS; .</p> <p>4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures.</p> <p>(A) . in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90 C (194 F), or less than: .</p> <p>(2) For all other machines, 82 C (180 F).</p> <p>4-901.11 Equipment and Utensils, Air-Drying Required.</p> <p>After cleaning and SANITIZING, EQUIPMENT and UTENSILS:</p> <p>(A) Shall be air-dried .</p> <p>4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.</p> <p>(A) . cleaned EQUIPMENT and UTENSILS, . shall be stored:</p> <p>(1) In a clean, dry location;</p> <p>(2) Where they are not exposed to splash, dust, or other contamination .</p> <p>5-204.11 Handwashing Sinks.</p> <p>A HANDWASHING SINK shall be located:</p> <p>(A) To allow convenient use by EMPLOYEES in FOOD preparation, FOOD dispensing, and WAREWASHING areas; .</p> <p>The facility's policy for Dietary- Mechanical Dishwashing, revised and dated effective 10/09/2023, included the following:</p> <p>. Purpose: To ensure dishes and utensils are cleaned under sanitary conditions. Dishes shall be cleaned and sanitized after each use.</p> <p>Policy: .</p> <p>A. Turn on the machine, checking temperatures to assure proper wash and rinse temperatures .</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. High temp machine: Wash- 140 F, . Rinse - 180 F .</p> <p>H. Allow clean dishes to air dry completely before storing or store in a manner that allows for air drying.</p> <p>I. If the same person is loading and unloading the racks, hands must be washed . before touching the clean surfaces of the items in the rack.</p> <p>Documentation:</p> <p>1. The temperature of the dish machine shall be recorded three (3) times a day. Temperatures out of specified range shall be reported .</p> <p>The facility's policy for Dietary- Hand Washing Techniques, revised and dated effective 10/09/2023, included the following:</p> <p>. Purpose: Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. dietary employees shall clean their hands in a handwashing sink .</p> <p>Policy: .</p> <p>6. Frequency of Handwashing:</p> <p>Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with . clean equipment and utensils . and also in the following situations:</p> <p>b. After hands have touched anything unsanitary i.e. (that is), garbage, soiled utensils/equipment, dirty dishes .</p> <p>During a kitchen observation on 06/12/2024 at 9:21 AM, Diet Aide #13 was seen pre-rinsing dirty trays and dishware at the dirty side of the dishwashing machine, while wearing gloves. Diet Aide #13 then went to the clean side of the dishwashing machine and removed clean trays from the rack and stacked them on a cart. Diet Aide #13 did not remove her gloves or wash her hands before touching the clean trays. A handwashing sink was observed just a couple of steps behind Diet Aide #13 in the dishwashing area; however, access to the handwashing sink was somewhat blocked by a two-compartment plate lowerator, which was filled with plates. At 9:24 AM, Diet Aide #14 entered the dishwashing area and rolled the cart stacked with trays away. At 9:27 AM, Diet Aide #13 took off her gloves, but did not wash her hands. Diet Aide #13 then pulled a rack of dishes from dishwasher to the clean drying area. At 9:28 AM, Diet Aide #13 was loading dirty dishes into a rack and spraying them with water. At 9:29 AM, Diet Aide #13 opened the dishwasher and moved freshly washed dishes to the clean side. Diet Aide #13 then unloaded other clean dishes from a different rack and stacked them on the clean side. Diet Aide #13 did not wash her hands prior to handing the clean dishes.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/12/2024 at 9:33 AM, the Kitchen Supervisor was asked to observe dishwashing with the surveyor. As dishwashing was going on, Diet Aide #14 was seen nearby starting to load trays from the stacked trays on the cart onto the delivery speed racks to be used for lunch service. As Diet Aide #14 removed each tray from the stack, he repeatedly used a white terry cloth square to dry each tray. Diet Aide #13 was again observed going from the dirty side to the clean side of the dishwashing machine without washing her hands. When asked the problem, the Kitchen Supervisor said Diet Aide #13 should have washed her hands. When asked the issue with Diet Aide #14's activity, the Kitchen Supervisor said, Wet trays. When asked if the trays should be air-dried, instead of towel-dried, to reduce the risk of cross-contamination; the Kitchen Supervisor said yes. The Kitchen Manager was then observed to be chewing gum. When asked about restrictions for chewing gum in the kitchen, the Kitchen Supervisor looked surprised and said, I didn't know that. This is the first time anyone told me that.</p> <p>On 06/12/2024 at 9:37 AM, Diet Aide #13 was asked the problem with going from the dirty side of the dishwashing machine to the clean side. Diet Aide #13 thought for a moment and said, I should have washed my hands. I didn't think.</p> <p>On 06/12/2024 at 9:38 AM. Diet Aide #13 was asked if temperatures had been checked on the dishwashing machine. Diet Aide #13 said it was running about 160 to 170 degrees. Diet Aide #13 was asked to run the dishwashing machine to confirm the temperatures. The Wash temperature was 157 F and the Final Rinse was 171 F. The plate on the dishwashing machine documented the minimum Wash temperature as 150 F and the minimum Final Rinse as 180 F. The Dish Machine Temperatures-Sanitation log sheet for June 2024 had the exact same numbers for the temperatures recorded for all three meals from June 1 to June 11; the repeated temperature for Wash was 160 and for Rinse was 180. Diet Aide #13 said the temperatures did vary, but they just recorded those numbers. Diet Aide #13 said if the temperature was 181 degrees F, they would record 180 degrees F. There were no temperatures yet recorded on the log sheet for June 12. The Kitchen Manager contacted Maintenance to come check the dishwashing machine.</p> <p>On 06/12/2024 at 9:43 AM, Diet Aide #14 was observed going to the hand sink in the dishwashing area, but he did not move the two-compartment plate lowerator. Instead, Diet Aide #14 reached over the two-compartment plate lowerator to wash his hands at the sink. Water splash from the sink and his hands hit the dishes in the two-compartment plate lowerator. The Kitchen Manager observed this also and said it was a contamination problem.</p> <p>On 06/12/2024 at 9:45 AM, the Maintenance Supervisor arrived to check the dishwashing machine. The Maintenance Supervisor asked if the Booster Heater was turned on.</p> <p>On 06/12/2024 at 9:55 AM, the Maintenance Supervisor said someone would have to come work on the dishwashing machine.</p> <p>On 06/12/2024 at 11:07 AM, a worn, plastic covered sign was observed above the handwashing sink in Dishwashing area, on which was printed, COMPLETE TEMPERATURE LOG AT THE BEGINNING OF EACH DISH CYCLE.</p> <p>On 06/13/2024 at 10:31 AM, a worn sign in a plastic sleeve was observed above the 3-compartment sink in the Dishwashing area, on which was printed, PLEASE DO NOT LEAVE BOOSTER ON.</p> <p>On 06/13/2024 at 11:47 AM, the Kitchen Manager said the Dishwashing machine repair person came yesterday (06/12/2024) and that a new booster heater needed to be ordered.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 06/13/2024 at 4:52 PM, the Maintenance Supervisor said the dishwashing machine was not getting to temperature for the Final Rinse. He said the Final Rinse temperature should be 180 to 185 degrees Fahrenheit. The Maintenance Supervisor further said the dishwasher was new, but the booster heater was older. He said they would be getting a new booster heater. When asked about the sign posted in the kitchen about turning off the booster heater, the Maintenance Supervisor said it was probably meant for overnight to save the life of the heating elements. The Maintenance Supervisor additionally said he did not actually know about the sign or its purpose.</p> <p>During an interview on 06/13/2024 at 5:31 PM, the Dietary Manager said she had been working at the facility for about two months. The Dietary Manager said cross contamination was the problem with going from working on the dirty side of the dishwashing machine and then going to the clean side without washing one's hands. The Dietary Manager said staff could not wear gloves on the dirty side of the dishwashing machine and then merely remove them to go to the clean side. The Dietary Manager further said you have to wash your hands. The Dietary Manager said dishwashing machine temperatures should be recorded three times a day, before washing dishes. The Dietary Manager said the problem with recording the expected temperatures and not the actual temperatures for the dishwashing machine was not knowing what the temperature actually was and you cannot guess that. The Dietary Manager further said if the water was not hot, it was not going to clean and sanitize. The Dietary Manager said the dishwashing machine's Final Rinse should reach 180 degrees Fahrenheit to sanitize the dishes or else the residents could get sick. The Dietary Manager said cross contamination was the problem with using a white terry cloth square to repeatedly to dry resident food trays and that they should be air-dried. The Dietary Manager said the problem with the two-compartment plate lowerator or any equipment being placed in front of the handwashing sink was that it blocked access to the sink. The Dietary Manager said cross contamination from splashed water was the concern with the employee leaning over the two-compartment plate lowerator to wash their hands at the handwashing sink. The Dietary Manager said food service employees were not allowed to chew gum in the kitchen. The Dietary Manager further said when chewing gum, spit can come out of the mouth. The Dietary Manager said the booster heater was the problem with the dishwashing machine and a new was being purchased as soon as possible. The Dietary Manager did not know about the sign posted in the kitchen about turning off the booster heater or the reason for it.</p> <p>During a phone interview on 06/13/2024 at 7:20 PM, the Registered Dietitian (RD) said infection control was the concern with staff going from working on the dirty side of the dishwashing machine and then going to the clean side, without washing their hands. The RD further said staff could not wear gloves on the dirty side of the dishwashing machine and then merely remove them to go to the clean side. The RD said the dishwashing machine's Wash and Final Rinse temperatures should be recorded at the beginning of the cycle. When asked the problem with staff recording the expected dishwashing machine temperatures and not the actual temperatures, the RD said they were not the same thing. The RD said the 180 F minimum temperature of the Final Rinse is needed to sanitize. The RD said repeatedly using a white terry cloth square to dry resident food trays was an infection control concern and that they should be air dried. The RD said infection control was the concern with the two-compartment plate lowerator or any equipment being placed in front of the handwashing sink. The RD further said cross contamination and infection control were problems resulting from the employee leaning over the two-compartment plate lowerator, which contained dishes, to wash their hands at the handwashing sink. The RD said food service employees were not allowed to chew gum in the kitchen due to germs. The RD further said if the gum left their mouth, it could get in the food.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49799</p> <p>Based on observations, interviews, and review of a facility policy Infection Prevention and Control Program, the facility failed to ensure staff washed their hands and stored resident hygiene supplies in a manner to prevent cross-contamination.</p> <p>On 06/12/2024 and 06/13/2024 two unlabeled bath basins were observed on the bathroom of adjoining resident rooms for Resident Identifier (RI) #22 and RI #66.</p> <p>On 06/14/2024 the facility Treatment Nurse failed to perform hand hygiene after cleaning RI #14's wound and before applying the treatment.</p> <p>This affected RI #22, RI #66, and RI #14.</p> <p>Findings include:</p> <p>A facility policy titled, Infection Prevention and Control Program dated 11/20/2023 documented:</p> <p>.Policy: .</p> <p>5. Hand Hygiene Protocol:</p> <p>a. All staff shall perform hand hygiene when coming on duty, between resident contacts, after handling contaminated objects, after PPE (Personal Protective Equipment) removal .</p> <p>b. Staff shall perform hand hygiene before and after performing resident care procedures.</p> <p>c. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedure.</p> <p>11. Facilities with communal bathrooms:</p> <p>a. Items such as wash basins, bed pans, etc. shall be placed in a bag that is clearly labeled and stored separately .</p> <p>RI #22 was admitted to the facility on [DATE].</p> <p>RI #66 was admitted to the facility on [DATE].</p> <p>On 06/12/2024 at 10:59 AM, a shared bathroom for RI #22 and RI #66 was observed with two gray wash basins on the bathroom floor.</p> <p>On 06/13/2024 at 11:00 AM the adjoining bathroom of RI #22 and RI #66 was observed with two unlabeled wash basins on the floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Ahc Millenium		STREET ADDRESS, CITY, STATE, ZIP CODE 5275 Millennium Drive Huntsville, AL 35806	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/2024 at 11:30 AM Certified Nursing Assistant (CNA) #25 reported that each resident should have their own basin, labeled with their name and room number. CNA #25 said, the basins should be covered and in a clear plastic bag.</p> <p>RI #14 was admitted on [DATE] with diagnoses that included Stage Four Sacral Pressure Ulcer.</p> <p>On 06/14/2024 at 08:18 AM the Treatment Nurse, Licensed Practical Nurse (LPN) #26 was observed providing wound care for RI #14. LPN #26 cleaned RI #14's sacral wound and applied the clean treatment to the wound. LPN #26 did not perform hand hygiene or change gloves after removing the soiled dressing and before applying the clean treatment.</p> <p>An interview was conducted on 06/14/2024 at 06:12 PM with the Risk Manager/Infection Preventionist. The Risk Manager/Infection Preventionist reported, according to the facility policy staff should wash their hands after all care and each time they are dirty. The Risk Manager/Infection Preventionist stated, staff should remove soiled gloves before they exit the room or when they finished care. The Risk Manager/Infection Preventionist stated, staff should not be wearing contaminated gloves when touching clean items. The Risk Manager/Infection Preventionist stated, the risk of picking up clean items while wearing dirty/soiled gloves was contamination.</p>		